No. 78-88

In the Supreme Court of the United States

OCTOBER TERM, 1978

DR. JOHN T. MACDONALD FOUNDATION, INC., d/b/a DOCTORS' HOSPITAL, A FLORIDA CORPORATION NOT FOR PROFIT, PETITIONER

v.

JOSEPH A. CALIFANO, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

MEMORANDUM FOR THE RESPONDENTS

WADE H. MCCREE, JR.
Solicitor General
Department of Justice
Washington, D.C. 20530

INDEX

CITATIONS

Cases:

Cases—Continued

Statutes and regulations:

Statutes and regulations—Continued

Miscellaneous:

In the Supreme Court of the United States

OCTOBER TERM, 1978

No. 78-88

DR. JOHN T. MACDONALD FOUNDATION, INC., d/b/a DOCTORS' HOSPITAL, A FLORIDA CORPORATION NOT FOR PROFIT, PETITIONER

v.

JOSEPH A. CALIFANO, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

MEMORANDUM FOR THE RESPONDENTS

OPINIONS BELOW

The *en banc* opinion of the court of appeals (Pet. App. 1-12) is reported at 571 F.2d 328. The first opinion of the panel (Pet. App. 24-36) and the opinion of the panel on rehearing (Pet. App. 13-23) are reported at 534 F.2d 633 and 554 F.2d 714. The

opinion of the district court (Pet. App. 37-46) is unreported. The opinions of the Secretary's delegates (Pet. App. 47-53) are not reported.

JURISDICTION

The judgment of the court of appeals was entered on April 17, 1978. The petition for a writ of certiorari was filed on July 15, 1978. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

QUESTIONS PRESENTED

1. Whether 42 U.S.C. 405(h) precludes review by district courts of determinations by the Secretary of Health, Education, and Welfare regarding computation of the amount owed petitioner for the reasonable cost of medical services it performed as a Medicare provider.

2. Whether the Court of Claims has jurisdiction, pursuant to 28 U.S.C. 1491, to review the Secretary's determinations.

STATEMENT

The Health Insurance For The Aged Act (commonly known as the Medicare Act), 42 U.S.C. 1395 *et seq.*, requires the Secretary of Health, Education, and Welfare to reimburse qualified "providers" for the "reasonable cost" of the medical services they furnish to eligible Medicare beneficiaries. 42 U.S.C. 1395g, 1395f(b). The Act provides that the reasonable cost of such services "shall be determined in accordance with regulations establishing the method

or methods to be used * * * in determining such costs." 42 U.S.C. 1395x(v)(1).[1]

The Secretary has promulgated 20 C.F.R. 405.486 (b)(1), a regulation governing, *inter alia*, the computation of reasonable costs to be allowed a provider hospital for its medical services when the hospital receives income through leasing one or more of its departments to physicians who are separately reimbursed under the Act for reasonable charges made for their services. The regulation specifies that any income "received by the hospital under such an arrangement shall be treated as a reduction of allowable costs of the hospital reimbursable through the hospital insurance program."

Petitioner, a general short-term hospital, became a provider of Medicare services in 1966. In fiscal years 1967 and 1968 petitioner leased its radiology department to three physicians, providing them with utilities and certain maintenance services and receiving from them payments based on a percentage of revenue taken in by the department. In fiscal years 1969 through 1972 petitioner leased the department to the same physicians on a different basis: petitioner assumed the department's operating costs and received a fixed fee plus a percentage of revenues in return. The lease arrangement generated net income for petitioner during each of the fiscal years 1967-1972.

---

[1] Except where noted otherwise, references to the Medicare Act are to provisions in the 1970 edition of the United States Code, which governed the claims at issue here.

As a provider of services, petitioner is required to file annual cost reports with the Blue Cross Association (BCA), and Blue Cross of Florida (BCF), its designated fiscal intermediaries, to supply a basis for determining the amounts properly reimbursable for its services under the Act.[2] For each of the fiscal years 1967-1972, BCF determined that the amounts claimed by petitioner for its services should be reduced by setting off the Medicare portion of the net income generated by the radiology department lease against petitioner's otherwise reimbursable costs for its entire hospital facility.[3] Petitioner appealed this determination for fiscal years 1967 and 1968 to the Blue Cross Association Medicare Provider Appeal Committee, which, after a hearing, upheld the determination as a proper application of 20 C.F.R. 405.486 (b)(1) (Pet. App. 47-49). On a subsequent appeal on the same issue with respect to fiscal years 1969-

[2] 42 U.S.C. 1395h permits the Secretary to appoint public or private agencies, known as fiscal intermediaries, to administer Medicare payments as agents for the Secretary. Pursuant to that provision, the Secretary's regulations provide (20 C.F.R. 405.651(c)): "[F]iscal intermediaries act on behalf of the Secretary, carrying on for him the administrative responsibilities imposed by the law. The Secretary, however, is the real party in interest in the administration of the program."

[3] The "Medicare portion" is the portion equivalent to the percentage of Medicare utilization of the hospital facilities. This calculation must be made because of the requirement in 42 U.S.C. 1395x(v)(1) that the Secretary take care to avoid placing the burden of Medicare costs on individuals not covered by Medicare.

1972, the Committee reached the same decision (Pet. App. 50-53).

Petitioner then instituted this action against the Secretary[4] in the United States District Court for the Southern District of Florida, asking the court to declare either (a) that the regulation in question requires only an offset of payments received from the radiology department lessees against petitioner's costs in connection with the department or (b) that the regulation as interpreted by the Secretary is void because it conflicts with the Medicare Act. Petitioner also sought an order requiring the Secretary to recompute the amounts owing to petitioner in fiscal years 1967-1972 without making the challenged offset.

The district court found that it had jurisdiction under the Administrative Procedure Act (APA), 5 U.S.C. 701-706, and upheld both the Secretary's interpretation of the regulation and its validity under the statute (Pet. App. 37-46). A panel of the court of appeals agreed that the APA supplied jurisdiction, but it reversed the district court's decision on the merits, holding that the Secretary abused his discretion by applying 20 C.F.R. 405.486(b)(1) to require a reduction in provider reimbursement (Pet. App. 24-36). The Secretary filed a timely petition for rehearing on the jurisdictional issue, but the court withheld ruling on it until after this Court decided *Califano* v. *Sanders*, 430 U.S. 99 (1977). The panel, with Judge Clark dissenting, then denied the petition

[4] References to "the Secretary" include the designated intermediaries.

for rehearing and held that, although *Sanders* precluded resting jurisdiction on the APA, jurisdiction nonetheless lies under 28 U.S.C. 1331 (Pet. App. 13-23).

The Secretary obtained leave to file a second petition for rehearing, with suggestion of rehearing *en banc*, which the court granted. The *en banc* court held that 42 U.S.C. 405(h) precludes all review in the district courts of pre-1973 reimbursement decisions of the Secretary.[5] The court observed, however, that the Court of Claims, in cases such as *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (1976), cert. denied, 430 U.S. 969 (1977), had held that it had jurisdiction under the Tucker Act, 28 U.S.C. 1491, to decide pre-1973 reimbursement disputes. Stating that this was "a holding that we are powerless to overturn" (Pet. App. 8), the court of appeals transferred the case directly to the Court of Claims pursuant to 28 U.S.C. 1406(c).

DISCUSSION

1. The court of appeals correctly determined that the district court had no jurisdiction to review these pre-1973 Medicare reimbursement claims.

Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), is incorporated into the Medicare Act

[5] The Act was amended in 1972 (86 Stat. 1422) and 1974 (88 Stat. 1459) to provide for judicial review of claims arising in accounting periods after June 30, 1973.

by 42 U.S.C. 1395ii.[6] The second sentence of Section 405(h) provides:

> No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided.

This Court noted in *Weinberger* v. *Salfi*, 422 U.S. 749, 757 (1975) (emphasis added), that Section 405 (h) "prevent[s] review of decisions of the Secretary *save as provided in the Act*" and that "sources of jurisdiction [outside the Act are] foreclosed by § 405 (h)" (*id.* at 764).

With respect to most Social Security claims the "herein provided" clause of Section 405(h) refers to Section 405(g), which generally provides for judicial review of "any final decision of the Secretary made after a hearing." See *Weinberger* v. *Salfi*, *supra*, 422 U.S. at 763-764.[7] But when Congress enacted the Medicare Act, it chose not to incorporate Section 405 (g). Instead Congress limited review of administrative actions under the Medicare Act to specific categories of disputes, not including reimbursement claims

[6] 42 U.S.C. 1395ii provides:

> The provisions of sections 406, 408, and 416(j) of this title, and of subsections (a), (d), (e), (f), (h), (i), (j), (k) and (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter.

[7] For purposes of this provision, "decision of the Secretary" includes the decision of his statutory delegate, such as, in this case, the Provider Appeal Committee.

by Medicare providers. See 42 U.S.C. 1395ff.[8] The limitation of review to specific categories of disputes was careful and deliberate. See S. Rep. No. 404, 89th Cong., 1st Sess. 54-55 (1965).

The 1972 and 1974 amendments to the review provisions of the Medicare Act support the conclusion that Section 405(h) precludes judicial review of respondent's claim for reimbursement. In 1972 Medicare providers urged Congress to lift the Act's barriers to judicial review. See, *e.g.*, *Hearings on H.R. 17550 Before the Senate Committee on Finance*, 91st Cong., 2d Sess. 679-701 (1970). In response, Congress established both a "Provider Reimbursement Review Board," and, for the first time, a limited right to judicial review for reimbursement disputes. Social Security Amendments of 1972, 42 U.S.C. (1970 ed., Supp. II) 1395*oo*. In 1974 the Act was further amended to provide judicial review for most Medicare provider disputes. 42 U.S.C. (Supp. V) 1395*oo*. In both instances, however, judicial review was made available only with respect to accounting periods ending *on or after* June 30, 1973. Thus Congress carefully considered the question of judicial review of Medicare provider reimbursement controversies, and it clearly understood and intended judicial review to be precluded for disputes, such as this one, involving pre-1973 periods.

[8] The categories of disputes for which the Act initially provided judicial review were claims by Medicare beneficiaries concerning entitlement to and the amount of benefits under Parts A and B of the Act and claims by providers concerning their status as providers and the termination of that status.

Petitioner is incorrect in contending (Pet. 18-20) that the *en banc* decision of the court of appeals conflicts with cases decided by other circuits after this Court's decisions in *Weinberger* v. *Salfi*, *supra*, and *Califano* v. *Sanders*, *supra*. The decisions on which petitioner relies (Pet. 18-19) concern the existence, extent, and basis of district court jurisdiction to review substantial constitutional issues—most notably claims of a denial of procedural due process—in Medicare reimbursement disputes not subject to the review procedures provided in the 1972 and 1974 amendments.[9] None, however, holds that district courts have jurisdiction over disputes, like the one presented here, concerning the proper interpretation of regulations and their application to the facts in a

[9] Five circuits have indicated that Section 405(h) does not preclude district court review of procedural due process claims in Social Security Act or Medicare Act cases, but they differ about the basis of jurisdiction. *Cervoni* v. *Secretary of Health, Education, and Welfare*, No. 77-1345 (1st Cir. June 27, 1978), slip op. 13-14 (jurisdiction based on 28 U.S.C. 1331) (dictum); *White* v. *Mathews*, 559 F.2d 852, 855-856 (2d Cir. 1977), cert. denied, No. 77-866 (Feb. 27, 1978) (28 U.S.C. 1361); *St. Louis University* v. *Blue Cross Hospital Service, Inc.*, 537 F.2d 283, 291-292 (8th Cir. 1976), cert. denied, 429 U.S. 977 (1976) (28 U.S.C. 1331); *Elliott* v. *Weinberger*, 564 F.2d 1219 (9th Cir. 1977) (28 U.S.C. 1361), petition for cert. pending, No. 77-1511; *Association of American Medical Colleges* v. *Califano*, 569 F.2d 101, 113 (D.C. Cir. 1977) (28 U.S.C. 1361) (dictum). The Seventh Circuit has held that district courts are barred by Section 405(h) from considering constitutional claims in pre-1973 Medicare provider reimbursement disputes. *Trinity Memorial Hospital* v. *Associated Hospital Service*, 570 F.2d 660, 667 (1977).

particular case.[10] Moreover, at least four post-*Salfi* decisions, like the *en banc* decision here, squarely hold that district courts lack jurisdiction over such non-constitutional questions. *Trinity Memorial Hospital* v. *Associated Hospital Service*, 570 F.2d 660, 666 (7th Cir. 1977); *Cervoni* v. *Secretary of Health, Education, and Welfare*, No. 77-1345 (1st Cir. June 27, 1978), slip op. 9-13, 18-19; *St. Louis University* v. *Blue Cross Hospital Service, Inc.*, 537 F.2d 283, 287-289 (8th Cir. 1976), cert. denied, 429 U.S. 977 (1976); *South Windsor Convalescent Home, Inc.* v. *Mathews*, 541 F.2d 910, 913 (2d Cir. 1976).

2. Although the court of appeals properly held that the district court had no jurisdiction, we believe that it erred in transferring the case to the Court of Claims. The court transferred the case on the authority of 28 U.S.C. 1406(c), which provides that "[i]f a case within the exclusive jurisdiction of the Court of Claims is filed in a district court, the district court shall, if it be in the interest of justice, transfer such case to the Court of Claims * * *." Even if a court of appeals, as well as a district court,

[10] Petitioner made no constitutional claim in the district court, but it suggests now (Pet. 24-25) that it is entitled by the Constitution to judicial review of the Secretary's determination that radiology department income must be used to offset overall hospital costs. This contention is groundless, for where, as here, there is "clear and convincing" evidence of a congressional intent to foreclose judicial review of such claims, the Constitution does not require judicial review. *Califano* v. *Sanders, supra*, 430 U.S. at 109; *Weinberger* v. *Salfi, supra*, 422 U.S. at 762.

may transfer cases pursuant to this provision (see *Panhandle Eastern Pipe Line Co.* v. *Federal Power Commission*, 343 F.2d 905, 908-909 (8th Cir. 1965)), the court of appeals nonetheless lacked power to make the transfer here because the case is not "within the exclusive jurisdiction of the Court of Claims" and hence does not meet the requirements of 28 U.S.C. 1406(c). For the reasons stated at pages 6-8, *supra*, Section 405(h) precludes review by *any* court of disputes of the kind presented here.

The Court of Claims has held that the Tucker Act, 28 U.S.C. 1491, gives it jurisdiction to hear Medicare provider reimbursement disputes.[11] See, *e.g.*, *Appalachian Regional Hospitals, Inc.* v. *United States*, 576 F.2d 858 (1978); *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (1976), cert. denied, 430 U.S. 969 (1977). This position, however, is inconsistent not only with the plain language of Section 405(h) but also with the principle that the Court of Claims cannot enter money judgments against the United States

[11] 28 U.S.C. (Supp. V) 1491 provides in pertinent part:

> The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort. * * * In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just.
>
> * * * * *

unless Congress has clearly authorized it to do so. Waivers of sovereign immunity from suits for money damages, which would give rise to Court of Claims jurisdiction under the Tucker Act, " 'cannot be implied but must be unequivocally expressed.' " *United States* v. *Testan*, 424 U.S. 392, 399 (1976), quoting from *United States* v. *King*, 395 U.S. 1, 4 (1969). The Medicare Act contains no provision indicating an intent to waive sovereign immunity to actions by Medicare providers, such as petitioner, for additional payments under the Act. Indeed, the inclusion of Section 405(h) in the Act indicates precisely the contrary.

We therefore adhere to the view, expressed in our petition for certiorari in *Whitecliff, Inc.* v. *United States*, *supra*, that the Court of Claims cannot hear Medicare provider disputes. Moreover, we believe that the issue continues to be important. The Secretary estimates that nearly two hundred Medicare cases not covered by any review provision in the Social Security Act or the Medicare Act either are pending in the Court of Claims or are pending in the district courts and susceptible to transfer to the Court of Claims by courts that decide to follow the holding in this case.[12] Those cases involve claims totaling more

[12] Of those two hundred cases, approximately 45 involve pre-1973 Medicare provider disputes. The Secretary also informs us that thousands more Medicare cases not subject to Social Security Act or Medicare Act review provisions are now being handled administratively. Moreover, even cases involving disputes governed by such review provisions may be affected, since the aggrieved parties might well seek to evade time and amount-in-controversy limitations by filing under 28 U.S.C. 1491 in the Court of Claims.

than $20 million. Courts continue to express uncertainty concerning whether the Court of Claims has jurisdiction to hear such cases[13] and, if so, what the scope of that jurisdiction is.[14]

We did not file a petition for a writ of certiorari to review the transfer order in this case because the Court, in denying our petition for a writ of certiorari in *Whitecliff*, apparently determined that the question of the Court of Claims' jurisdiction does not warrant review. If the Court should decide, however, that it is now appropriate to examine the extent of the Court of Claims' jurisdiction, then it can do so in the present case. The jurisdiction of the court of appeals to transfer the case depends on 28 U.S.C. 1406(c), and Section 1406(c) makes the authority to transfer depend on the jurisdiction of the Court of Claims. Although the court of appeals thought (see Pet. App. 8) that it was powerless to disagree with the Court of Claims' assertion of jurisdiction, this Court is not similarly bound. Moreover, because the issue goes to the jurisdiction of both the transferor court and the

[13] In *Sierra Vista Hospital, Inc.* v. *Califano*, No. 75-2738 (9th Cir. argued Aug. 10, 1978), the court has ordered the proceeding held in abeyance and directed the government to advise it concerning further developments in this case.

[14] Compare *Trinity Memorial Hospital* v. *Associated Hospital Service*, *supra*, 570 F.2d at 667 (jurisdiction over procedural due process claims), with *South Windsor Convalescent Home, Inc.* v. *Mathews*, *supra*, 541 F.2d at 914 (no limitation specified) and *Whitecliff, Inc.* v. *United States*, *supra*, 536 F.2d at 351 (jurisdiction to review compliance with Constitution and governing statute).

transferee court, it may be reviewed here even though we have not filed a petition for certiorari. See, *e.g.*, *Abney* v. *United States*, 431 U.S. 651 (1977); *Liberty Mutual Insurance Co.* v. *Wetzel*, 424 U.S. 737 (1976).

CONCLUSION

We do not oppose the granting of the petition for a writ of certiorari.

Respectfully submitted.

WADE H. MCCREE, JR.
Solicitor General

SEPTEMBER 1978

☆ U. S. GOVERNMENT PRINTING OFFICE: 1978 273495 120